eHealth Financing Workgroup Charter Activities and Recommendations

Responsibilities:
Develop options for funding electronic health records in all size health care settings and for the operation of a statewide public-private health information infrastructure.

I. Assumptions and premises underlying draft recommendations:

1. Financing is needed for three levels of infrastructure: 1) appropriate HIT adoption and use by providers, 2) HIE through RHIOs or other exchange mechanisms at the regional level, and 3) statewide HIE.

2. A fully implemented HIE environment requires consistency of platforms and standards for inter-operability that do not yet exist, and must be developed at the national level.

3. Approach must be statewide, politically feasible, and consistent with federal initiatives.

4. The RHIO concept does not capture a standard set of information exchange activities or functions, and thus the acronym does not describe any specific model. Rather, the eHealth Finance Work Group will focus on recommendations for financing designated individual functions and step-wise, phased-in modular adoption of functions.

5. The definition of the scope and functions of a state-level RHIO effort will determine the strategies for obtaining long-term sustainable financing.

6. The plan will require phase in over time, but HIE promotion should not crowd out resources for bring all providers at a baseline level of capability for internal clinical and patient safety systems and the internal capture and aggregation of data.

7. Marginal costs must correspond with marginal benefits. This will vary by type of provider/constituent, but each stakeholder needs to realize a proportional ROI.

8. The system requires re-engineering processes and workflow, and adoption phase-in will incur productivity costs.

9. Must accommodate existing efforts and incorporate legacy systems. Avoid creating multiple login environments where HIT exists but interface capability is currently lacking.

10. Organizations - particularly low volume unaffiliated – may need help financing and implementing EHR systems.

11. Costs of participation in HIE need to be scaled for smaller rural communities, with consideration of the relative benefits in various markets.

12. HIE will allow for flexible flow of clinical data across systems and referral centers, rather than limiting access within existing referral relationships and proprietary networks.

13. The Wisconsin eHealth Action Plan will provide overall cost estimates and strategies: The actual RHIOs will develop business plans and a clear value model for each HIE function they pursue.

14. HIT/HIE is a public good and the investment in its development and operations should be partially funded from public sources.

II.   Status Report on Assignments

Assignments:	Draft Findings & Recommendations
1) Articulate the value on investment and the business case for investment in health information exchange.	1) The business case and ROI for electronic health records, HIT and HIE has not been well established in practice, but only in theory through modeling and projections in the literature. 2) The literature reports a wide range of costs associated with HIT; Fiscal estimates of implementation will reflect that range, but also note that costs will decrease over time. 3) A RAND analysis (Health Affairs, 2005) estimated that national adoption of the EHR could lead to "more than $81 billion" in annual savings. 4) But Goodman and colleagues, also writing in Health Affairs: "It is unrealistic to hold out widespread adoption of HIT as a net cost saver." "Do It for the Quality." 5) HIE: Walker and colleagues, writing in Health Affairs, estimated that information exchange across providers, hospitals, public health, and payers, could save $77.8 billion annually. 6) "The EHRs greatest promise arguably lies in the support of [patient centeredness, shared decision making, teaming, group visits, open access, outcome responsibility, the chronic care model, and disease management], versus the prospect of less efficiency, greater costs, inconsistent quality, and unchanged malpractice burdens resulting from a simple engraftment into the current health care system." (Sidorov 2006)

Assignments:	Draft Findings & Recommendations

	HIT: Business Case
	Estimated Start-Up and Maintenance Expenses (includes hardware, software, training, personnel, productivity affects)
	• Solo and small group practices: $44K start-up, $8.5K/year maintenance (Miller, 2005)
	• MGMA average: $33K start-up, $1.5K/year maintenance
	
	ROI gains by category (Miller 2005)
	• The average practice paid for its EHR in 2.5 years and gained more than $23K in net benefits per FTE providers. Gross financial benefits $33K/FTE/year (range $1K-$42K):
	    ○ Increased coding levels – 52% of benefits - $17K average
	    ○ Efficiency related - 48% of benefits- average $15K per FTE provider. (40% from decreased personnel costs and 8% from increased patient visits.)
	Productivity gains:
	7) Lowering personnel costs: EHR can enable clerical staff reductions amounting to $13K per physician per year. (Miller, 2005)
	8) But one analysis shows EHR increased documentation time among physicians by about 17%, while CPOE increased it by 98%. (Poissant 2005)
	9) Kaiser Permanent EHR resulted in 5-9% decrease in office visits replaced by telephone contacts. (Garrido, 2005)
	Billing Optimization:
	• EHR can "auto-populate or scour the medical record to justify a greater intensity of services. "Increased coding levels," better "capture of charges" and fewer "billing errors" can produce ROI. (Miller 2005, Wang 2003)
	• Arguably, as physicians are prone to under-documentation, EHRs can increase health care costs by billing more for the same services without any corresponding increase in quality (Sidorov 2006)
	
	Quality and Safety:
	• Evidence is mixed. Physicians might resent the loss of professional autonomy or have limited tolerance for on-screen prompts.
	• "The EHR has yet to be quantified or consistently used to reduce malpractice premiums or health care costs." (Sidorov 2006)
	
	HIE Business Case:

Assignments:	Draft Findings & Recommendations
	Santa Barbara County financial analysis ■ found "positive returns to HIE in all except small communities (e.g., one hospital and less than 100 physicians), even they ignoring improvements in clinical efficiency. In [these] one-hospital markets, there is little difference between enterprise-data access and regional data sharing, so...these markets do not have a business case for sharing data beyond the enterprise." ■ At face value, HIE provides moderate ROI. Overall magnitude of returns is relatively low. ■ But peer-to-peer technology can scale the benefit to the cost of operation and carries little overhead. Can be self-funded. ■ Key variable is physician adoption and use: ROI is completely related to lowering the volume of manual data handling. ■ NIHIT Briefing (2005): "hospitals and providers foot 97% of the ongoing costs (of information exchange), yet receive just 56% of the potential benefits. The remaining benefits are dispersed among payers and other stakeholders." ROI by constituent in Medium and Large Regions ■ Each constituent benefits from providing data to any set of physicians on an enterprise level (stand-alone web-enablement or one-to-one interaction), without "regionalization." ■ Organization gains benefits from participation in the regional network, arising from having a single place for physicians to get all relevant data for their patients (i.e. many-to-many interaction). ■ Physician offices get a very high rate of return in the form of office efficiencies. ■ Imaging center have a slightly negative return from regional component, but is balanced by positive return from stand-alone web-enablement. ■ Every organization has positive overall returns from regional data sharing. **Low Hanging Fruit for Early Wins** ■ ePrescribing, Medication management ■ eLaboratory ■ On-line tools for chronic disease management ■ Emergency room data transfer (?) Potential Phase-In (North Carolina)

Assignments:	Draft Findings & Recommendations
	Phase I: point of care medication management, automated refill, formulary and benefits information, and eRx Phase II: elab and radiology results ordering and results at point of care. Phase III: EHR HIE functions most commonly pursued in the first two years are as follows: clinical messaging, medication reconciliation, PH outbreak surveillance, electronic referrals and authorizations, electronic signature, e-prescribing, P4P/quality data reporting, electronic billing support. (eHealth Initative Toolkit)

2). Identify existing and potential funding sources to support development of the ehealth infrastructure.	Contributed income:
	Federal grants (AHRQ, NHIN)
	DHFS
	WI Telecommunications Fund
	Foundations
	(Note: the work group is sharply divided about the potential to seek BC/BS foundation funds, which could potentially be proposed for use after March 2009, the end of the current five-year plan for that fund.)
	
	Tax Credits
	Potential lenders: bond issue, WHEFA, in combination with other credit enhancements
	
	Potential earned income:
	Stakeholder contributions
	Membership fees – based on size and/or usage
	Subscription/use/transaction fee – based on benefit to participants
	    ▪ $ per clinical result delivered
	    ▪ $ per covered life per month
	    ▪ $ per hour for technical assistance
	    ▪ $ per month for a license to use a particular software package over the web.
	Programs or Service fee: for example, for participation in group purchasing arrangements, educational services.
	
	P4P or other forms of reimbursement financing, particularly through state payers – Medicaid, ETF

3). Examine approaches and successful examples of financial strategies to	▪ More than 70% of RHIO income, on average, from grants and other forms of contributed income. (Healthcare IT Transition Group, 2006). ▪ Expect as much as 1/3 of total RHIO revenues from government grants and philanthropy

Assignments:	Draft Findings & Recommendations
increase adoption of health information technology and ehealth data exchange from within the state and from other regions.	• While does not resemble a commercial enterprise or fee-based nonprofit healthcare provider, this business model is consistent with other non-profit organizations and appropriately reflect RHIOs' role as a public good. • Grants may supplement, but are unlikely to be a viable source for ongoing funding. (AHIMA 2006) EHR group purchasing strategies successful, with contributions from payers that are potential beneficiaries of physicians' use of HIT. (Rhode Island) Utah HIN only provides services that have business value to its members and for which members will pay. Includes membership fees, and per claim transaction fees.
4). Propose financing strategies for funding health information technology and ehealth for both start-up and long term including the appropriate roles of the public and private sectors.	• State government programs, including Medicaid, ETF, biosurveillance, and public health services, should tie in with the state-level RHIO architecture and design payment incentives for providers statewide to adopt and participate in the system. • Resources should be directed to those stakeholders who must be engaged but who may lack the resources to contribute financially (safety net providers, FQHCs, RHCs, CAHs, local health departments). • Many rural hospitals, in particular lack interface engines and interface expertise, and often have limited IT resources in house. They will need interfacing hardware, software, and expertise resources to participate in HIE. • Pay-for-performance incentives
5).Identify specific financial actions required to support the first key product types (as identified by the Patient Care work group and approved by the Board), provide an estimate for the total cost of implementation of the first key product types and for total cost of implementation of the Wisconsin Action Plan.	*1. Model developed* (see table below)

1. Model developed

	start-up $ needs	Maintenance Needs	Potential Revenue				Expected RIO
			contributed	earned	loans	tax credits	
HIT (including EHRs) physician offices							
HIT (including EHRs) hospitals							
HIE (including RHIO/s)							
Central Coordination							

Assignments:	Draft Findings & Recommendations
	2. Exploration of funding sources

Potential contributors/grantors	Potential Lenders	Potential fees	Other potential earned income
DHFS Foundations AHRQ WI Telecommunications Fund	Bond issue WHEFA combined with other financing	Membership Transaction User fees Patient subscription BioT PH Surveillance	P4P from payers State payers – ETF, Medicaid

3. Estimating Wisconsin's Relative Proportion of the Costs of National Health Information Network (based on Wisconsin as 2% of the national population)

Kaushal, et al. *Annals of Internal Medicine,* August 2005
$156B in K   2% = $3.2 B
$48 B annual operating costs   2% = $960 million

RAND, Health *Affairs,* August 2005
HIT costs: $115 B   2% = $2.3B

Walker, et al. Health Affairs, January 2005
Level 4 HIE: $276B   2%= $5.5 B

Assignments:	Draft Findings & Recommendations
6). Coordinate with and give input to other groups.	In progress.

7)/ Present findings, analysis, and recommendations to the Board at the August 3, 2006 meeting.	▪ Specificity of the Governor's eHealth Action Plan:
	   o Will include fiscal estimates for broad/universal adoption of EHR/HIT and recommendations about how to leverage and provide incentives for such adoption.
	   o Will include potential strategies and funding sources for RHIOs and other HIE initiatives.
	Implementation will require a more detailed, comprehensive business plan for the state-level RHIO, which includes defining capital and operating expenses of the project and the sources of revenue for the project.

III. Issues for discussion:

- Will the state-level RHIO be conducting technology operations (e.g., actually hosting and sharing health care data) and if so what operations and data?

- Should initial funding be used for actually building out some of the technology architecture?

- What is the role for state incentives for adoption?
    - How to assure equity for early adopters/investors/pioneers while promoting broader diffusion if technology.
    - Structure HIE without crowding-out private sector market developments and within-enterprise investment priorities.

- What is integrated vision for phase-in of functions, systems, and providers over time?